Department of Medical Assistance Services
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MEDICAID MEMO

TO: All EPSDT Personal Care and Attendant Care Provider, Hearing Aid Providers, Audiologists, Assistive Technology Providers, and Private Duty Nursing Providers Participating in the Virginia Medical Assistance Programs

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 10/3/2012

SUBJECT: Notification of EPSDT Service Authorization Processing Moving to Keystone Peer Review Organization (KePRO) – ***Effective November 1, 2012***

The purpose of this memorandum is to notify providers rendering specific EPSDT services that Keystone Peer Review Organization (KePRO) will receive requests for certain services, effective November 1, 2012.

General Information Regarding Service Authorization

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS member by a DMAS enrolled provider prior to service delivery and reimbursement. Some services do not require authorization and some may begin prior to requesting authorization. Providers are instructed to refer to the appropriate provider manual to determine when service authorization is required for specific procedures and to check the DMAS web portal for the most current fee file. The fee file indicates whether a specific HCPCS/CPT requires service authorization for DMAS covered services. Instructions on how to access the fee file are provided within this memorandum.

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the member's continued Medicaid/FAMIS eligibility, the provider's continued eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual member, a provider, a service code, an established quantity of units, and for specific dates of service.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the member's Medicaid eligibility determination.

EPSDT Services Requiring Service Auth through KePRO

KePRO will begin reviewing requests for the following services, effective November 1, 2012**.** Any requests received through October 31, 2012 at DMAS' EPSDT Unit will be processed at DMAS. KePRO will receive clinical data on these cases and will honor all final dispositions made by DMAS. For pend responses issued by DMAS through October 31 2012, providers are to respond to DMAS with the necessary information to complete the final disposition.

Documentation submitted to KePRO will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.

PA Service type (used to request service type)	Procedure Codes	Procedure Code Definition	Direct Data Entry (DDE) through Secure Web Portal or Fax Form
0092 EPSDT EPSDT AT, Hearing Aids, Chiro, Ortho	V5014	Repair/Modification Of Hearing Aid	Direct Data Entry through KePRO's Atrezzo Connect OR DMAS 363 *Outpatient Services Authorization Request Form*
	V5030	Hearing Aid, Monaural, Body Worn, Air Conduction	
	V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction	
	V5050	Hearing Aid, Monaural, In The Ear (Ite)	
	V5060	Hearing Aid, Monaural, Behind The Ear (Bte)	
	V5070	Glasses, Air Conduction	
	V5080	Glasses, Bone Conduction	
	V5095	Semi-Implantable Middle Ear Hearing	
	V5100	Hearing Aid, Bilateral, Body Worn	
	V5120	Binaural, Body	
	V5130	Hearing Aid, Binaural, Ite	
	V5140	Hearing Aid, Binaural, Bte	
	V5150	Binaural, Glasses	
	V5170	Hearing Aid, Cros, In The Ear	
	V5180	Hearing Aid, Cros, Behind The Ear	
	V5210	Hearing Aid, Bicros, In The Ear	
	V5220	Hearing Aid, Bicros, Behind The Ear	
	V5242	Hearing Aid, Analog, Monaural, Cic (Completely In The Ear Canal)	
	V5243	Hearing Aid, Analog, Monaural, Itc (In The Canal)	
	V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC	
	V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)	
	V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In-the-Ear)	
	V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE (Behind-the-Ear)	
	V5248	Hearing Aid, Analog, Binaural, Cic	
	V5249	Hearing Aid, Analog, Binaural, Itc	
	V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)	
	V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)	

	V5252	Hearing Aid / Digitally Programmable / Analog /Binaural /ITE (In-the-Ear)	
	V5253	Hearing Aid / Digitally Programmable / Analog /Binaural /BTE(Behind-the_Ear)	
	V5254	Hearing Aid, Digital, Monaural, Cic	
	V5255	Hearing Aid, Digital, Monaural, Itc	
	V5256	Hearing Aid, Digital, Monaural, Ite	
	V5257	Hearing Aid, Digital Monaural Bte	
	V5258	Hearing Aid, Digital, Binaural, Cic	
	V5259	Hearing Aid, Digital, Binaural, Itc	
	V5260	Hearing Aid, Digital, Binaural, Ite	
	V5261	Hearing Aid, Digital, Binaural, Bte	
	V5264	Ear Mold/ Insert, Not Disposable, Any Type	
	V5266	Battery For Use In Hearing Device	
	V5267	Hearing Aid Supplies	
	V5273	Assistive Learning Device Cochlear Implant Type	
	V5274	Assistive Learning Device (FM System)	
	V5298	Hearing Aid, Not Otherwise Classifi	
	V5299	Hearing Service, Miscellaneous	
0092 EPSDT EPSDT AT, Hearing Aids, Chiro, Ortho	T5999	Assistive Technology	Direct Data Entry through KePRO's Atrezzo Connect OR DMAS 363 *Outpatient Services Authorization Request Form*
0090 EPSDT Private Duty Nursing	S9123	EPSDT Skilled Nursing RN	Direct Data Entry through KePRO's Atrezzo Connect OR DMAS 98 *Community Based Care Waiver Request Form*
	S9124	EPSDT Skilled Nursing LPN	
	G0162	EPSDT Congregate Nursing RN	
	G0163	EPSDT Congregate Nursing LPN	
0091 EPSDT Personal Care and Attendant Care	T1019	EPSDT Agency Directed Personal Care Services	Direct Data Entry through KePRO's Atrezzo Connect OR DMAS 98 *Community Based Care Waiver Request Form*
	S5126	EPSDT Consumer Directed Personal Care Services	
0098 EPSDT MCO Carve Out Svcs	S9123	EPSDT Skilled Nursing RN	Direct Data Entry through KePRO's Atrezzo Connect
	S9124	EPSDT Skilled Nursing LPN	
	G0162	EPSDT Congregate Nursing RN	

	G0163	EPSDT Congregate Nursing LPN	OR DMAS 98 *Community Based Care Waiver Request Form*

Methods of Submission to KePRO

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KePRO.

KePRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax and phone. Submitting through DDE puts the request in the worker queue immediately; faxes are entered by the administrative staff in the order received. For direct data entry requests, providers must use Atrezzo Connect Provider Portal. For DDE submissions, service authorization checklists may be accessed on KePRO's website to assist the provider in assuring specific information is included with each request. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com.

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. The Atrezzo Connect User Guide is available at http://dmas.kepro.com : Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Specific Information for Hearing Aids (Service Type 0092)

Hearing Aid services are only available for Medicaid members under the age of 21 through EPSDT. Only hearing aid providers (provider type 038) and audiologists (provider type 044) may submit hearing aid requests. Providers must submit requests when they are aware of the need for the hearing aid/service and prior to delivery. Providers should expect a response from KePRO within 3 business days of receipt. Hearing Aids are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

KePRO will utilize McKesson InterQual® Criteria in making medical necessity determination for hearing aids and related devices. Where McKesson InterQual® Criteria does not exist, KePRO will utilize DMAS criteria as specified in the *EPSDT Hearing and Audiology Manual* found under Provider Resources/Manuals on the DMAS website.

Hearing Aids

Web Portal Submission	Fax Submission
Validate specific questions on CMN OR upload form and attach to request in Atrezzo	DMAS 363 *Outpatient Services Authorization Request Form*
Upload Most Recent Audiology Evaluation and attach to request in Atrezzo	DMAS 352 – Certificate of Medical Necessity (CMN)
Provider's Invoice Cost	Most Recent Audiology Evaluation

Complete web based checklist *EPSDT Hearing Aids and Related Devices* and attach to request in Atrezzo	Provider's Invoice Cost

Specific Information for Assistive Technology (Service Type 0092)

Assistive Technology services are available only for Medicaid members under age 21 through EPSDT. AT services are not covered by DMAS for members age 21 and older unless enrolled in specific waivers. Only DME providers (provider type 062) or AT providers (provider type 056 and specialty 016 or 046) may submit AT requests for service authorization. Providers must submit requests when they are aware of the need for AT. There is no retroactive authorization, except in cases where retroactive Medicaid eligibility determination is made. Providers should expect a response from KePRO within 3 business days of receipt. These services are also available as MCO carved out services. Assistive Technology devices are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

KePRO will utilize DMAS criteria as outlined in *DMAS' EPSDT Supplement* for AT.

Assistive Technology (AT)

Web Portal Submission	Fax Submission
Complete web based checklist *EPSDT Assistive Technology* and attach to request in Atrezzo	DMAS 363 *Outpatient Services Authorization Request Form*
Upload Letter of Medical Necessity signed and dated by physician; OR licensed therapist evaluation report signed and dated by physician. Attach Letter of Medical Necessity to request in Atrezzo	Letter of Medical Necessity signed and dated by physician and licensed therapist evaluation; OR licensed therapist evaluation report signed and dated by physician
Provider's Invoice Cost	Provider's Invoice Cost

Specific Information for Private Duty Nursing (Service Type 0090)

Providers must request services prior to start of care or the request will be approved starting with the date it is received. KePRO will utilize DMAS criteria as specified in the *EPSDT Supplement Nursing Manual* and will provide a response within 5 business days of receiving the initial request. Private Duty Nursing services are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

Private Duty Nursing

Web Portal	Fax Submission
Complete web based questionnaire	DMAS 98 *Community Based Care Waiver Request Form*
Upload CMS 485 *Physician's Orders* signed and dated by ordering physician OR Upload physician order with same data elements as on the CMS 485, signed and dated by ordering physician Attach to request in Atrezzo	CMS 485 *Physician's Orders* signed and dated by ordering physician OR physician order with same data elements as on the CMS 485, signed and dated by ordering physician
Upload DMAS 62 *EPSDT Medical Needs Assessment* and attach to in Atrezzo	DMAS 62 *EPSDT Medical Needs Assessment*

If a member is enrolled in waiver that offers PDN and there is a service authorization request for EPSDT private duty nursing, the services will be authorized under the waiver first. If additional hours are needed and they are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT private duty nursing only, and then is later enrolled in a waiver that offers private duty nursing, then the provider must request an end date for the EPSDT service in order for the member to be enrolled in the waiver and receive private duty nursing.

Specific Information for School Based Private Duty Nursing, MCO Carve Out (Service Type 0098)

If a child is in a Managed Care Organization (MCO) and is in need of Private Duty Nursing in the school setting, providers are to request services under Service Type 0098 (EPSDT MCO Carve Out Svcs). Providers must request services prior to start of care or the approval will start on the date it was received. KePRO will utilize DMAS criteria as specified in the *EPSDT Supplement Nursing Manual* and will provide a response within 5 business days of receiving the initial request. Private Duty Nursing services are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members except when Private Duty Nursing services are required in the school setting. When nursing is required in the school setting for MCO enrolled members, the services are availableas MCO carved out services.

Private Duty Nursing – MCO Carve Out, School Based

Web Portal	Fax Submission
Complete web based questionnaire	DMAS 98 *Community Based Care Waiver Request Form*
Upload CMS 485 *Physician's Orders* signed and dated by ordering physician OR Upload physician order with same data elements as on the CMS 485, signed and dated by ordering physician Attach to request in Atrezzo	CMS 485 *Physician's Orders* signed and dated by ordering physician OR physician order with same data elements as on the CMS 485, signed and dated by ordering physician
Upload DMAS 62 *EPSDT Medical Needs Assessment* and attach to request in Atrezzo	DMAS 62 *EPSDT Medical Needs Assessment*

If a member is enrolled in waiver that offers PDN and there is a service authorization request for EPSDT private duty nursing, the services will be authorized under the waiver first. If additional hours are needed and they are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT private duty nursing only, and then is later enrolled in a waiver that offers private duty nursing, then the provider must request an end date for the EPSDT service in order to be enrolled in the waiver and receive private duty nursing.

Specific Information for Personal Care, and Attendant Care (Service Type 0091)

Providers are to submit requests for service authorization within 10 business days prior to the start of care (SOC), or the approval will start on the date it was received. It is recommended that providers submit their request within 10 business days of the expiration of the existing authorization period if the member continues to need services. If the request is not submitted prior to the expiration of the existing request, the approval will start on the date it was received. KePRO will utilize criteria as specified in the DMAS *EPSDT Supplement B, Personal Care*, and make a final determination within 5 business days of receiving the initial request. These services are available as MCO carved out services.

Personal Care and Attendant Care

Web Portal	Fax Submission
Questionnaire entitled *EPSDT- T1019/S5126 Questionnaire*	DMAS 98 *Community Based Care Waiver Request Form*
	DMAS 7 *EPSDT Personal Care Services Functional Assessment*
	DMAS 7A *EPSDT Personal Care Program Agency and Consumer Directed Plan of Care*
	DMAS 99 *Community Based Care Recipient Assessment Form*

If a member is enrolled in waiver that offers personal care and/or attendant care, and there is a service authorization request for EPSDT personal care or attendant care, the services will be authorized under the

waiver first. If additional hours are needed, and are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT personal care or attendant care only, and then is later enrolled in a waiver that offers either of these services, then the provider must request an end date for the EPSDT service in order for the member to be enrolled in the waiver and receive personal and/or attendant care services.

Authorizations that Currently Span Past November 1, 2012

Providers that currently have an approved service from DMAS' EPSDT Unit that is approved past November 1, 2012 need to do nothing. The authorization will be honored and there should be no break in the provider's service. Providers must use the service authorization number issued on their approval letter generated from MMIS for submitting claims. If the provider determines that the individual needs a continuance of that approved authorization, the request must be submitted to KePRO prior to the expiration of the initial authorized period. Providers are encouraged to submit the request within 14 business days of the expiration date of the current approved time period. KePRO will receive all authorizations that have been performed by DMAS' EPSDT Unit, both denied and approved, that span past November 1, 2012. If a provider and/or member appeals any decision made by DMAS' EPSDT Unit, DMAS will act upon the appeal through to resolution.

General Information for All Submissions

- KePRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms, web based service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.

- KePRO will approve, deny, or pend requests. If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. Do not send responses to pends piecemeal since the information will be reviewed and processed upon initial receipt. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination. In the absence of clinical information, the request will be submitted to the supervisor for an administrative review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instruction on how to file an appeal is included in the MMIS generated letter.

- There are no automatic renewals of service authorizations. Providers must submit requests for continuation of care needs, with supporting documentation, prior to the expiration of the current authorization.

- Personal Care and Attendant Care providers are not to begin providing services until they receive a final determination on their request.

- Providers must verify member eligibility prior to submitting the request. There are several mechanisms available for providers to verify member eligibility, located at the end of this memorandum.

- Authorizations will not be granted for periods of member or provider ineligibility.

- There is no retroactive authorization periods for services identified in this memorandum, with the exception of hearing aid codes identified above.
- Requests will be rejected if required demographic information is absent.

- Providers must use the DMAS forms appropriate for the service(s) being requested.

- Providers should take advantage of KePRO's web based checklists/information sheets for the services(s) being requested. These sheets provide helpful information to enable providers to submit information relevant to the services being requested.
- Providers must submit a service authorization request under the appropriate service type. Service authorization requests cannot be bundled under one service type if the service types are different.

How to Find Out if Procedure Code(s) Require Service Authorization

In order to determine if services need to be prior authorized, providers should go to the DMAS website: http://www.dmas.virginia.gov and look to the right of the page and click o the section that says Procedure Fee Schedule Files. You will now see a page entitled DMAS Procedure Fee Files and CPT Codes. Determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV version opens easily in an Excel spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 - No PA is required
01 – Always needs PA
02 – Only needs PA if service limits are exceeded
03 – Always needs PA , with per frequency

To determine whether a service is covered by DMAS, access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below:

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.